

# HEALTH OCCUPATIONS CREDENTIALING CRIMINAL RECORD CHECK PROGRAM

## REQUIRED FACILITY INFORMATION

FACILITY NAME : \_\_\_\_\_

FACILITY TYPE: \_\_\_\_\_

DATE OPENED: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

### MAILING ADDRESS

STREET: \_\_\_\_\_

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAIN CONTACT PHONE: \_\_\_\_\_